



**THE EAR FOUNDATION®**  
OF ARIZONA

HEAR for Kids® is a program for children who have been identified as needing audiology assessment as a result of a hearing screening. HEAR for Kids® is made possible by a grant from St. Luke's Health Initiatives and private donations.

Parent/Guardian Please Complete this Section

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Person Responsible for the child: \_\_\_\_\_

Relationship to Child:  Mother  Father  Guardian Phone Number: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Is child eligible for free or reduced lunch program?  Yes  No  Unknown

*(If unknown or under age 3, fill out Income and Expense portions of the form)*

**Income**

Total Household income for the past 12 months: \$\_\_\_\_\_

*Include: Wages/Salary, Pension, Social Security, Child Support and any other income.*

**Expenses**

Number of family members living in your home \_\_\_\_\_

Total Allowed Deductions for the past 12 months: \$\_\_\_\_\_

*Include: Total medical/dental not paid for by health insurance or third party, Annual rent or mortgage payment, Annual payments for primary vehicle, Dependent Care. For dependant care, use the following calculations:*

*Number of children in childcare \_\_\_\_\_ x \$200 x number of months \_\_\_\_\_ = \_\_\_\_\_*

*Number of incapacitated adults receiving care \_\_\_\_\_ x \$100 x number of months \_\_\_\_\_ = \_\_\_\_\_*

**Parent responsibility**

If your child is eligible and funding is available, you will receive a \$50 voucher to be used as payment for one office visit. The EAR Foundation of Arizona will *not* accept financial responsibility for any additional tests, treatment or office visits.

By signing this form you agree to release information to The EAR Foundation of Arizona, HEAR for Kids® Program. Information specific to your child, and his/her hearing loss, may be shared with other medical, audiology or early intervention professionals or agencies. Information that doesn't specifically identify your child may be published, reviewed for utilization, quality assurance or used to pursue funding for the program.

Parent or Guardian: \_\_\_\_\_ Date \_\_\_\_\_

**HEAR for Kids®-Audiology Voucher Request**

**Audiologist/Nurse/School Health Staff Please Complete this Section**

- Specify which Voucher is being requested:  
 Audiology Eval.    Unsedated ABR/ASSR    Sedated ABR/ASSR    CI Programming
- If the child is eligible or enrolled in any of the following, that will provide the services, they will not be eligible for this program:  
 AHCCCS                               Yes    No                      Enrolled KidsCare                       Yes    No  
 Indian Health Services    Yes    No                      Other Health Insurance    Yes    No
- Determine eligibility by subtracting amount in the **Expenses** section from the amount in the **Income** section and reviewing the following chart (current as of 4/11).

| Number in Family | Annual Income | Number in Family | Annual Income | Number in Family | Annual Income |
|------------------|---------------|------------------|---------------|------------------|---------------|
| 1                | \$16,335      | 3                | \$27,795      | 5                | \$39,255      |
| 2                | \$22,065      | 4                | \$33,525      | 6                | \$44,985      |

For each additional person, add \$5,730

*If the family income is at or below the listed amount for the number of family members the child will be eligible. If money is available, a voucher will be faxed to you to be given to the family. If the family does not meet the qualifications but there are special circumstances, please call Lylis Olsen at (602) 690-3975.*

- Fax *both* sides of this form to HEAR for Kids at (602) 296-0425.
- If you have questions you can call Lylis Olsen at (602) 690-3975 or email [lylisolson@msn.com](mailto:lylisolson@msn.com)
- HEAR for Kids will fax a voucher to the number listed, usually within 48 hours. Call or email if you do not receive a voucher within 5 days.
- When you receive the voucher, give it to the family and assist them (as needed) to make an appointment with an appropriate provider.

**Referring person responsibility:**

By submitting this form, I acknowledge that I have verified income and expenses, believe that this family is eligible and that all other resources have been explored. The EAR Foundation's HEAR for Kids Program is the payor of last resort and cannot replace insurance, other public or private programs.

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Name of Referring Person: \_\_\_\_\_ Date \_\_\_\_\_  
 School/Agency/Facility \_\_\_\_\_  
 Address: \_\_\_\_\_ zip code: \_\_\_\_\_  
 Phone Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Fax Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Email: \_\_\_\_\_

Please keep a copy of this application and the proof of income and deductions.  
 The EAR Foundation of Arizona may request this documentation to verify eligibility